HB

498

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

240 Main Street, Suite 500
Juneau, Alaska 99801-2101

MEMORANDUM January 17, 1992

SUBJECT: Medicaid Coverage for Pregnant Women (Work Order No. 7-LS1802)

TO: Representative Georgianna Lincoln
ATTN: Pat Jackson

FROM: Terri Lauterbach
Legislative Counsel

Enclosed is a draft in response to your request to expand Medicaid to cover pregnant women and infants.

Section 1 amends AS 47.07.020(b) to add women and children under age one whose family income is between 133% and 185% of the federal poverty line as an optional Medicaid group. Those whose income is below 133% are already covered as a federally mandated group. According to Gordon Landis, the population referred to in the capitalized and bracketed language on page 2, lines 25 - 27, has become a federally mandated group so the group no longer needs to be listed as an optional group in this subsection. (Mandated groups are covered by AS 47.07.020(a).)

Section 2 of the draft adds "substance abuse rehabilitative services for pregnant women" as an optional Medicaid service.

Section 3 of the draft places the new substance abuse services at the top of the priority listing in AS 47.07.035. I have used this placement as a starting point based on what seems to be a recent trend in the legislature to put new services at the top of the list instead of trying to assess the relative merits of the new service compared to the services previously covered. You could, however, choose a different starting point for placement of the new service.

You will also note that the draft adds "case management and nutritional services for pregnant women" as fourth on the priority listing in sec. 3. This addition is not necessary for your bill; it is more in the nature of a "cleanup" amendment. When these services were added to AS 47.07.030(b) in 1988, there was no corresponding

Legal Services Memorandum

amendment to AS 47.07.035 to place them on the priority listing. There should have been.

I have placed the 1988 services fourth because clinical social workers' services and psychologists' services were added after 1988, and, as "newer" services, should precede the 1988 addition. However, other post-1988 additions were placed in the middle of the priority list (prescribed drugs and mammography screening), so an argument could be made that case management and nutritional services for pregnant women wouldn't necessarily have been placed at the top of the list if the proper amendment of AS 47.07.035 had been made in 1988. In other words, you could choose a different priority than that suggested by this draft.

In fact, you don't have to deal with the priority listing for the case management and nutrition services for pregnant women at all. It is not necessary to the main purpose of your bill. However, since your bill does add another service for pregnant women, the question of how to prioritize it in relation to other services that are specifically for pregnant women is almost certain to arise. That is why I felt that, perhaps, this draft would be a good one in which to correct the 1988 oversight.

However, I am mindful that any changes in the priority listing of AS 47.07.035 are generally controversial. If you do not wish to correct the 1988 oversight in this draft, we need not do so.

I hope you find this description of the draft helpful. Please let me know if you have questions or comments.

TML:pl:mi
92-023.plm

Enclosure

Southcentral Foundation

March 2, 1992

The Honorable Georgianna Lincoln
House of Representatives
Alaska State Capitol
Pouch V
Juneau, Alaska 99811

Dear Representative Lincoln:

As you know, Southcentral Foundation operates the only residential treatment center in Alaska that is specifically for pregnant women who are suffering from drug and/or alcohol abuse and addiction. Our program Dena A Coy, opened last July with funding from both the Indian Health Service and the Alaska Department of Health and Social Services. Funding realities being what they are -- and facing declining revenues in the State -- the staffing coverage for the program is very "tight," and additional sources of financial support are very important to us.

In this context, I would like to testify in support of House Bill 498, with the backing of the Board of Directors and the staff of Southcentral Foundation as well. This law, when passed, will enable Dena A Coy to garner third party income to increase staff and, ultimately to provide services to a larger number of women. Given the fact that (a) Fetal Alcohol Syndrome is one of the most devastating and expensive health problems Alaskans encounter, (b) it can be completely eliminated by abstinence during pregnancy, and (c) there is a great need for increasing treatment services to pregnant women, House Bill 498 appears to be the most cost-effective way for the Legislature to respond.

Please let me know if my staff or I can assist you in any way regarding this bill. We will contact our local legislators to communicate our support.

Sincerely yours,

SOUTHCENTRAL FOUNDATION

Katherine Grosdidier
Executive Director

ALASKA STATE LEGISLATURE
Representative Georgianna Lincoln

HESS Committee, Co-Chair
Resources Committee, Vice-Chair

Budget Subcommittees
Health and Social Services
Revenue

P.O. Box V
Juneau, Alaska 99811

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Arctic Village
Beaver
Bettles
Birch Creek
Chalkyitsik
Chuathbaluk
Crooked Creek
Evansville
Fort Yukon
Galena
Grayling
Holy Cross
Hughes
Huslia
Kalskag
Kaltag
Koyukuk
Lake Minchumina
Lime Village
Lower Kalskag
Manley Hot Springs
Marshall
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Minto
Mountain Village
Nikolai
Nulato
Pilot Station
Pitkas Point
Rampart
Red Devil
Ruby
Russian Mission
Shageluk
Sleetmute
St. Mary's
Stevens Village
Stony River
Takotna
Tanana
Telida
Tuluksak
Tyonek
Venetie
Wiseman

MEMORANDUM

TO: House Health, Education and Social Services Committee Members

FROM: Representative Georgianna Lincoln GL

DATE: March 5, 1992

RE: House Bill 498 - Medicaid Coverage for Pregnant Women

HB 498 would add substance abuse rehabilitative services for pregnant women as an optional Medicaid statute. Additionally, it would expand case management and nutritional services for pregnant women from the currently federally mandated level of 133% of the Federal Poverty Level to 185%.

While the state has made strides in Fetal Alcohol Syndrome/Fetal Alcohol Effect initiatives in recent years, we still have a long way to go. Children born to substance abusing mothers suffer irreversible lifelong consequences. Clearly, intervention and early treatment are critical to healthy outcomes for these children.

Substance Abuse Rehabilitative Services

In 1991, Dena A Coy, an 18 bed prematernal home for substance abusing pregnant women opened its doors. While the program will need a little more time before it can begin to generate statistics, those involved in the management and direction of the facility are already optimistic about the outcomes for the mothers and their newborn babies. The State Office of Alcoholism and Drug Abuse established a policy in 1990 that pregnant women would be given priority for substance abuse treatment. Adding substance abuse rehabilitation to the medicaid options would allow medicaid-eligible women to access treatment services.

Case Management and Nutritional Services

The Omnibus Reconciliation Act of 1989 mandated pregnant women and children under age 6 be provided with Medicaid coverage if their family income is less than 133% of the Federal Poverty Level. States are authorized, however, to expand that option for pregnant women and infants up to one year to 185% of the Federal Poverty Level. A list of states who have opted to provide case management services above 133% is attached.

sponsor statement

The 1989 Legislative Research Agency report *Economic Impact of Fetal Alcohol Syndrome in Alaska* "conservatively estimated" the **lifetime cost of each Fetal Alcohol Syndrome birth** in Alaska to be **$1.4 million.** Estimating 26 FAS children born in Alaska each year, lifetime costs of each cohort of FAS births would be nearly $40 million. Lifetime costs for individual with **Fetal Alcohol Effects**, children who have been affected by alcohol but do not exhibit characteristics of the full syndrome, were estimated at $64 million. The study did not include numerous health, education, and life-skill services. Additionally, the loss of quality of life or human potential are impossible to quantify in dollars, but are real costs to society as well.

FAS/FAE are preventable birth defects. Moreover, whenever drinking is stopped during pregnancy, the risks of fetal alcohol effects and the consequences of alcohol exposure are decreased. I urge your support of House Bill 498 as an additional tool i promoting healthy outcomes for Alaska's babies.

TANANA CHIEFS CONFERENCE, INC.
122 FIRST AVENUE
FAIRBANKS, ALASKA 99701-4897
PHONE (907) 452-8251 FAX (907) 451-8836

March 12, 1992

Representative Georgianna Lincoln
Alaska State Legislature
Pouch V
Juneau, Alaska 99811
VIA FAX 465-2652

RE: Support for HB2, HB3, and HB498

Dear Representative Lincoln,

This is to provide the endorsement of the Tanana Chiefs Conference for the above two bills:

We understand that HB2 and HB3 are intended to increase taxes on alcohol and tobacco sales. The TCC is supportive of increasing revenues through this approach. Increased cost is known to have some impact on overall use, and the revenues should be considered in the long-term funding of prevention and treatment services.

We also support HB498, which will provide for Medicaid funding for substance abuse treatment for pregnant women. We have endorsed the development of services for these individuals at the Dena A Coy center in Anchorage, and feel that Medicaid assistance for these services will increase the access for eligible persons. Indian Health Services resources for these types of programs are inadequate to meet the existing and projected need for these services.

Please communicate to the House HESS committee our support for the passage of these proposals.

Sincerely,

Paul Sherry, Director
Department of Health Services

cc: Will Mayo, President, TCC

Southcentral Foundation

HIGHLIGHTS FROM DENA A COY

Southcentral Foundation's prematernal treatment program, Dena A Coy, opened in July, 1991, with funding from the Indian Health Service and the Alaska Department of Health and Social Services. The program includes both residential and outpatient treatment for pregnant women who are suffering from alcohol abuse, alcoholism, and/or drug addiction. The current facility is a renovated apartment building that does not meet the needs of the program. There are 18 beds for residential clients, the capacity for four infants and/or children, and an outpatient program for six.

- To date Dena A Coy has treated 34 women clients.
- A total of 16 infants have been born to women in the program since it opened in July.
- Of the births, 13 have not exhibited any abnormalities; three are being monitored for possible Fetal Alcohol Syndrome or Fetal Alcohol Effects.
- There is one outpatient client at the present time; the possibility of shifting the outpatient program to serve as after-care for clients who have completed the residential component is being considered.
- Dena A Coy is receiving increasing amounts of attention, both within the State and across the Nation.
- A separate small grant from the March of Dimes has recently been received to assist Southcentral Foundation in paying for the travel of women from outside Anchorage to fly in to be admitted to the program.
- With funding for a new building, Dena A Coy can expand to treat more women, further decreasing the incidence of Fetal Alcohol Syndrome, Fetal Alcohol Effects, and other substance abuse related birth defects in Alaska.

670 W. Fireweed Lane, Suite 123, Anchorage, Alaska 99503
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STATE OF ALASKA

WALTER J. HICKEL, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF ALCOHOLISM AND DRUG ABUSE

3601 C STREET, SUITE 358
P.O. BOX 240249
ANCHORAGE, ALASKA 99524-0249
PHONE: (907) 561-4213

SUMMARY OF STATEWIDE FAS/FAE PREVENTION ACTIVITIES
(since Mother's Day, 1991)

* Dena A Coy, the 18-bed, four bassinet prematernal home for pregnant, substance abusing women, operated by Southcentral Foundation through grants from Department of Health and Social Services (DHSS) and Indian Health Service (IHS), opened July 31, 1991.

* In September, the Centers for Disease Control signed agreements with the DHSS and IHS to accomplish three specific goals:

1. Assist the State of Alaska in developing, implementing, and evaluating FAS surveillance systems;

2. Provide technical and programmatic evaluation of the IHS FAS programs and data;

3. Develop model surveillance, data analysis, and program evaluation methods which could be used to assist other States, communities, Native American populations, Circumpolar and other nations.

* As mandated by SB 409, school district training on the needs of individual students who have alcohol and other drug related disabilities.

* IHS reports FAS coordinators in each of the 12 regions.

* FAS Task Forces have been formed or are on-going in Barrow, Bethel and Fairbanks.

* FAS Parent Support groups have been formed or are on-going in Fairbanks and Anchorage. Barrow will hold first meeting in March.

* High Risk Family Coalitions are active in Anchorage and Juneau.

* The Broken Cord aired on TV on February 3. An 800 number was on the screen for people to call for more information following the broadcast. KYBR, in Barrow, is reading the book over the air.

* Trainings:
  - June 3-4, 1991: 250 attended conference sponsoring Dr. Ira Chasnoff, of National Association for Perinatal Addiction and Research.
  - June, 1992: Dr. Barry Zuckerman, developmental and behavioral pediatrician, will present in Juneau, Fairbanks, and Anchorage.

* Presentations:
  - Alaska Association of School Boards
  - State Principals Association
  - AAEYC
  - Infant Learning Program conference

Prevention Activity in Alaska

Revised 3/12/92

POSITION PAPER
COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 498

"An Act relating to Medicaid coverage for pregnant women and infants; and reordering the priorities granted to optional services under the Medicaid program; and providing for an effective date."

Analysis:
Section 1 of CS HB No. 498 would amend AS 47.07.030(b) to add an optional service to Alaska's Medicaid program: substance abuse rehabilitative services for pregnant women.

Section 2 of CS HB No. 498 would amend 47.07.035 to place case management and nutritional services for pregnant women #4 in the list of optional services and optional eligible groups to be deleted in the event that the Medicaid appropriation is insufficient to fund some or all optional services. (Those two services were added to AS 47.07.030 in 1988, but they were not placed in the priority listing of AS 47.07.035 at that time.)

Section 2 would also place substance abuse rehabilitative services for pregnant women as #1 in the priority list of AS 47.07.035, first to be deleted in the event of a funding shortfall. Section 2 places the optional group of eligible pregnant women proposed by this bill 22nd in the listing of options to be deleted.

Discussion
Substance abuse rehabilitation services would provide Medicaid reimbursement for some of the therapies and training provided pregnant women through the Division of Alcoholism and Drug Abuse grantees' programs. However, federal restrictions on these services would not allow reimbursement for all treatment activities in these programs. Also, Medicaid federal regulations prevent us from paying for the cost of room and board in residential treatment programs, even though such programs are a most effective way of treating substance-abusing pregnant women.

Our experience with delivering case management services to pregnant women indicates that there is a very substantial need for substance abuse services for them, and there are currently very few services.

We believe the sponsor of this bill intends to restrict this service to grantees of DADA, and not to open it to private sector participation at this time. If this is correct, we support the restriction. The existing Medicaid services options do not allow for any Medicaid reimbursement of Division of Alcoholism and Drug Abuse services. Adding this new service will allow us to begin to introduce Medicaid federal matching funds into alcoholism and substance abuse services. This kind of refinancing is a key strategy this Department wants to employ as a way of protecting essential programs in the face of declining state revenues.

However, we would be better able to control expenditures and resist pressures for expansion if this intent were made explicit by amending AS 47.07.900 (Definitions) to define substance abuse rehabilitation services for pregnant women as services provided by grantees of the Department. We respectfully recommend that the

Legislature consider making this change in CS HB No. 498:

AS 47.07.900 is amended by adding a new paragraph to read:

(13)"Substance abuse rehabilitation services" means services provided by a drug or alcohol treatment center that is funded with a grant under AS 47.30.475.

We understand the sponsor may be considering changes in the priority order proposed by Section 2. We believe the rationale we perceive behind how the Legislature has previously placed items in this listing would suggest that substance abuse services, insofar as they may partially fund existing state-funded activities with federal matching funds, are most like the "clinic services" option, which performs this function for the community mental health system. Perhaps these two services should be placed together in mid-list.

Also, there may be valid arguments for separating case management and nutrition services and re-placing these the options. Case management for pregnant women was established by the Legislature in 1988 as an "administrative" service and consists solely of Medicaid 75% federal funding for five Division of Public Health Public Health Nurses who serve high-risk pregnant women. We would argue for placement of this service near the clinic option in the priority list.

Nutritional services are very different from case management services, for these services are performed by a tiny number of private registered dietitians who serve pregnant women who have severe nutritional risking factors such as gestational diabetes. Because of Alaska's shortage of dietitians, we do not expect billing for this service to exceed $20,000 this year. Because of the small number of our clients who would be affected if this service were deleted, and because of the prospects clients have to obtain nutritional help form their physicians, we would argue for a placement of this service at or near the top of the priority list.

Position

We believe CS HB 498 proposes an essential service addition to Medicaid, and that is does so with an intent and cost that is realistic in light of the State's very bleak revenue outlook. We believe it is both cost effective and sound public policy to support services for substance-abusing pregnant women to the maximum extent possible.

We support the passage of this bill.

Recommended by: Kim Busch Date: 3-12-92

Kimberly B. Busch
Director
Division of Medical Assistance

Approved by: Theodore A. Mala Date: 3/12/92

Theodore A. Mala, MD, MPH
Commissioner

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. CS HB 498

Revision Date: 3/12/92 Department Affected: DH&SS

Title: An act relating to Medicaid coverage for for pregnant women... BRU: Medicaid

Component: Medicaid Non-Facilities

Sponsor: Lincoln, et al

Requestor:

COMPONENT SERIAL NO. 0229

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	53.5	35.7	37.7	39.8	42.0	44.3
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	95.3	209.6	230.1	253.1	278.4	306.2
MISCELLANEOUS						
TOTAL OPERATING	148.8	245.3	267.8	292.9	320.4	350.5
CAPITAL						
REVENUE FUND SOURCE:						

FUNDING (Thousands of Dollars)

GENERAL FUNDS	15.8	22.5	24.5	27.0	29.7	32.7
FEDERAL FUNDS	94.9	139.0	151.1	164.5	179.1	195.1
OTHER FUND SOURCE: IA	38.1	83.8	92.2	101.4	111.6	122.7
TOTAL	148.8	245.3	267.8	292.9	320.4	350.5

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY:	0	0	0	0	0	0

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary.)

Three Fiscal notes relate to CS CB 498. See attached analysis.
All HB 498 fiscal notes dated prior to 3/10/92 are not relevant to CS HB 498.

Prepared by: Kimberly Busch, Director Phone: 465-3355

Division: Medical Assistance Date: 3-12-92

Approved by Commissioner: Theodore A. Mala

Agency: Department of Health and Social Services Date: 3/12/92

Distribution (by Preparer: Leg. Fin., Legislative Sponsor, Requestor,OMB/DBR,Gov.Legis. Ofc., & Impacted Agency(ies)

Revised 3/12/92

FISCAL NOTE ANALYSIS
CS HB NO. 498

Substance Abuse Rehabilitation Services for Pregnant Women

We assume it is the intent of HB 498 to provide rehabilitative services to approved grantees of the Division of Alcoholism and Drug Abuse, and not to open those services to the private sector at this time. Initially, this services will cover treatment services (not room and board costs) for Medicaid-eligible pregnant women in all of the 4 grantee residential programs that accept or specialize in pregnant women services.

FY 93 costs include one-time system contractual costs for establishing a new service in the Medicaid Management Information System, report modifications, and providers' manuals and training for a total of $22.5 (75% federal, 25% state general fund match). Contractual costs-also include an RSA with the Division of Alcoholism and Drug Abuse for the 50% federal matching funds for a position in that division (CF DADA fiscal notes).

Because of the need to modify the system, promulgate regulations, and train providers, a start date of 1/1/93 is assumed for this service. FY 93 costs are estimated to pay for rehabilitative services during 2100 resident days, at a total cost of $95.3 (50% federal, 50% state general fund match).

FY 94 costs are computed at FY 93 x 2 (for a full 12 months) plus a 10% growth in service as capacity grows in residential treatment facilities and as other grantees offering some pregnant women outpatient therapy services enroll as providers. FY 95 and forward, we assume a 10% growth rate.

Contractual costs for claims processing, at $6.23 per claim, are estimated at $2.8 for FY 93, $6.2 for FY 94, and increasing at 10% per year thereafter. Costs are 75% federal, 25% state general fund.

COSTS	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
Contractual-DADA	28.2	29.5	30.9	32.3	33.7	35.2
Contractual-Claims	25.3	6.2	6.8	7.5	8.3	9.1
Grants/Claims	95.3	209.6	230.1	253.1	278.4	306.2
Total	148.8	245.3	267.8	292.9	320.4	350.5
REVENUE						
Federal	94.9	139.0	151.1	164.5	179.1	195.1
IA-DADA	38.1	83.8	92.2	101.4	111.6	122.7
New Med. SGFM	15.8	22.5	24.5	27.0	29.7	32.7
Total	148.8	245.3	267.8	292.9	320.4	350.5

"New Medicaid SGFM" is the total net new cost to the State of CS HB No. 498.

FISCAL NOTE ANALYSIS
CS HB NO. 498

The potential fiscal advantage to the grants system in DADA is the difference between the Medicaid payments the system receives (grants/claims amount), minus the transferred funds from DADA:

	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
Medicaid Payment	95.3	209.6	230.1	253.1	278.4	306.2
Minus IA	38.1	83.8	92.2	101.4	111.6	122.7
Potential Advantage	57.2	125.8	137.91	151.7	166.8	183.5

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. CSHB 498

Revision Date: March 10, 1992
Title: An Act Providing Medicaid Coverage for pregnant women...
Sponsor: Lincoln, Ellis, Ulmer, B. Davis et al
Requestor:

Dept. Affected: Health & Social Services
BRU: Alcohol & Drug Abuse Services
Component: Administration

COMPONENT SERIAL NO. 302

Expenditures/Revenues (Thousands of Dollars)

OPERATING	FY93	FY94	FY95	FY96	FY97	FY98
PERSONAL SERVICES	45.4	47.1	48.9	50.7	52.6	54.6
TRAVEL	5.0	5.5	6.0	6.6	7.2	7.8
CONTRACTUAL	5.0	5.3	5.6	5.9	6.2	6.5
SUPPLIES	1.0	1.1	1.2	1.3	1.4	1.5
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	56.4	59.0	61.7	64.5	67.4	70.4
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	28.2	29.5	30.9	32.3	33.7	35.2
FEDERAL FUNDS						
OTHER	28.2	29.5	30.9	32.3	33.7	35.2
TOTAL	56.4	59.0	61.8	64.6	67.4	70.4

POSITIONS:

FULL-TIME	1.0	1.0	1.0	1.0	1.0	1.0
PART-TIME						
TEMPORARY						

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary)

See attached analysis

Prepared by: Suzanne W. Perry
Division: DA Alcoholism & Drug Abuse
Phone: 465-2071
Date: March 10, 1992

Approved by: Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health and Social Services
Date: March 10, 1992

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
OMB
Impacted Agency(ies)

(Rev 12/91)

Fiscal Note

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. CSHB 498

Revision Date: March 10, 1992
Title: An Act Providing Medicaid Coverage for pregnant women...
Sponsor: Lincoln, Ellis, Ulmer, B. Davis, et al
Requestor:

Dept. Affected: Health & Social Services
BRU: Alcohol & Drug Abuse Services
Component: Alcohol & Drug Abuse Grants
COMPONENT SERIAL NO. 1239

Expenditures/Revenues (Thousands of Dollars)

OPERATING	FY93	FY94	FY95	FY96	FY97	FY98
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	<38.1>	<83.8>	<92.2>	<101.4>	<111.6>	<122.7>
MISCELLANEOUS						
TOTAL OPERATING	<38.1>	<83.8>	<92.2>	<101.4>	<111.6>	<122.7>
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	<38.1>	<83.8>	<92.2>	<101.4>	<111.6>	<122.7>
FEDERAL FUNDS						
OTHER						
TOTAL	<38.1>	<83.8>	<92.2>	<101.4>	<111.6>	<122.7>

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary)

See attached analysis

Prepared by: Suzanne Perry
Division: Alcoholism & Drug Abuse
Phone: 465-2071
Date: March 10, 1992

Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health and Social Services
Date: March 10, 1992

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
OMB
Impacted Agency(ies)

(Rev 12/91)

CSHB 498
Fiscal Note Analysis

There are two primary treatment facilities which regularly treat pregnant women. There is one treatment center which is exclusively for pregnant women, and there is one post-treatment (half-way house) facility for substance abusing women.

The costs of treatment in these facilities are as follows:

1. Juneau Recovery Unit (co-ed facility) $231/bed/day
   (specialized hospital), average length of stay 90 days

2. Reflections $96/bed/day
   This is a 12 bed women's only facility. Pregnant women get priority. Average length of stay 90 days

3. Dena A Coy $125/bed/day
   This is a pregnant women's only 18 bed facility. Average length of stay 200 days (This facility is primarily IHS funded. This refinancing effort would not alter the amount of federal IHS funds)

4. New Dawn (Alaska Women's Resource Center) $70/bed/day
   This is a 10 bed women's only halfway house or post-treatment facility. Pregnant women get priority if they refuse Dena A Coy or are not accepted for some reason. Average length of stay 120 days.

The average cost is $130/bed/day if all facilities are included. If only the primary treatment facilities are included, the average cost is $150/bed/day.

As medicaid will not pay for room and board costs, we estimate treatment costs to be 70% of the total cost. Therefore, of a total cost of $150/bed/day, $105 would be medicaid reimbursable.

The assumptions which were used to develop the fiscal impact on grants include the following:

FY 93 -- six months of regulation development, and program training followed by six months of actual client activity.

-- It is estimated that each year would see a 10% increase over the initial year.

-- JRU saw 3 pregnant women during the year with each remaining in treatment for 90 days, their cost would be $43.7.

-- Reflections saw 6 pregnant women during the year with each remaining in treatment for 90 days, their cost would be $24.2.

-- Dena A Coy saw 6 pregnant women during the year with each remaining in treatment for 200 days, their cost would be $105.0.

-- New Dawn (AWRC) saw 6 pregnant women during the year with each remaining in treatment for 120 days, their cost would be $17.6.

The Division of Alcoholism and Drug Abuse recently began collecting information on pregnancy status of women. It is not possible to determine from available information how many of these women were medicaid eligible.

Substance abuse treatment for pregnant women is a relatively new approach, and targeting medicaid eligible women has not historically been done.

During the transition period, one full year after the regulations are effective, it is anticipated that treatment centers would be required to hire and train additional staff to handle medicaid billings. While this staff would not necessarily be full time, it is anticipated that a part-time person would be necessary. Therefore, a retention of 20% of grant funds would be required. That is, for each $100 of medicaid to be reimbursed, $20 of grant funds would not be supplanted, but would be retained.

It is also anticipated that the Division of Alcoholism and Drug Abuse would require a staff specialist in medicaid to assist programs with this effort. This position would be located in Anchorage as three out of four of the programs currently seeing pregnant women are located in Anchorage. This position would be an Administrative Assistant II at a range 14. This position would be able to provide written and on-site technical assistance to all programs seeing pregnant women. The current COLA of 3.6% was used for salaries and 5% used for other costs after FY '93. A figure of $5.0 was used for travel as this is one half of the travel normally required of a Health Facilities Surveyor. It is anticipated that there would be several trips to Juneau, Fairbanks, and perhaps Bethel to assist programs. Contractual and supplies are standard figures used by the Division for budgeting purposes.

It is anticipated that this position would be Medicaid funded.

Estimates generally accepted in the nation are that each dollar spent on prenatal care cost-avoids up to $11, and we believe that no one questions the value of infant health services and preventive health care. The current Healthy Baby Program makes good social and health policy sense, and it also makes good fiscal sense when it is viewed from a long-term perspective.

The poverty level increases each year. The current and proposed poverty-level income qualifying standards are:

Household Size	133%	185%
2	$1272	$1769
3	$1602	$2229
4	$1932	$2688

(A pregnant women by herself is considered a household of 2.)

HB No. 498 also adds substance abuse rehabilitation services for pregnant women on Medicaid.

This service would provide Medicaid reimbursement for some of the therapies and training provided pregnant women through the Division of Alcoholism and Drug Abuse grantees' programs. However, federal restrictions on these services would not allow reimbursement for all treatment activities in these programs, and Medicaid cannot pay for the cost of room and board in residential treatment programs, which are often a most effective way of treating substance abusing pregnant women.

Our experience with case management services to pregnant women indicates that there is a very substantial need for substance abuse services for them, and there are currently very few services. We believe the sponsor of this bill intends to restrict this service to grantees of DADA, and not to open it to private sector participation at this time.

If this is correct, we support the restriction. Adding this new service will allow us to begin to introduce Medicaid federal matching funds into alcoholism and substance abuse services which have been funded exclusively with State funds. This kind of refinancing is a key strategy this Department is employing as a way of protecting essential programs in the face of declining state revenues.

However, we would be better able to control expenditures and resist pressures for expansion if this intent were made explicit by amending AS 47.07.900 (Definitions) to define substance abuse rehabilitation services for pregnant women as services provided by grantees of the Department. We respectfully recommend that the Legislature consider making this change in HB No. 498.

DHSS Position

Position

We believe that HB No. 498 proposes two very important and very desirable additions to Alaska's Medicaid program. News of this bill's introduction was applauded by hundreds of Department employees across the State who work with the Healthy Baby program and with pregnant women, who know the unmet needs that exist, and who know the importance and cost effectiveness of good prenatal and newborn care.

Unfortunately, the costs of HB No. 498 are so high, and the size of our current revenue shortfall is so large, that the Department cannot support the passage of HB No. 498 at this time. The current fiscal crisis virtually guarantees that the Medicaid program will have to be reduced for FY93; to add so expensive a new eligible group now could result in the need for additional services and eligible group reductions that could be so severe as to risk the health and well-being of our existing recipients.

Recommended by: _____
Kimberly B. Busch
Director
Div. of Medical Assistance

Date: 3/1-92

Approved by: _____
Theodore A. Mala, MD, MPH
Commissioner

Date: 4 March 1992

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. House Bill 498

Revision Date: March 3, 1992
Dept. Affected: DHSS
Title: An Act Relating to Medicaid Coverage for pregnant women and infants; and reordering the priori
BRU: State Health Services
Component: Maternal, Child & Family Hea
Sponsor: Lincoln, Ellis, Ulmer, B.Davis, Gruenberg, Koponen, Bruckman
Requestor: House Finance Committee
COMPONENT SERIAL NO. #290

Expenditures/Revenues (Thousands of Dollars)

OPERATING	FY93	FY94	FY95	FY96	FY97	FY98
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	-250.0	-250.0	-250.0	-250.0	-250.0	-250.0
MISCELLANEOUS						
TOTAL OPERATING	(250.0)	(250.0)	(250.0)	(250.0)	(250.0)	(250.0)
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	(250.0)	(250.0)	(250.0)	(250.0)	(250.0)	(250.0)
FEDERAL FUNDS	0.0	0.0	0.0	0.0	0.0	0.0
OTHER	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	(250.0)	(250.0)	(250.0)	(250.0)	(250.0)	(250.0)

POSITIONS:

FULL-TIME	0.0	0.0	0.0	0.0	0.0	0.0
PART-TIME	0.0	0.0	0.0	0.0	0.0	0.0
TEMPORARY	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of current year impact: N/A

ANALYSIS: (Attach a separate page if necessary)

These funds will be replaced with Medicaid funds because this legislation will provide Medicaid coverage to those women who were previously covered by State General Funds.

Prepared by: Peter M. Nakamura, MD, MPH
Division: Public Health
Phone: (907) 465-3090
Date: 3/3/92

Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health and Social Services
Date: 4 - March 92

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
OMB
Impacted Agency(ies)

(Rev 12/91)

FN (250.0) Public Health (MCH)

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. HB 498

Revision Date: 1/17/92
Department Affected: Health & Social Services
Title: An act relating to Medicaid Coverage
BRU: Public Assistance Administration
Component: Eligibility Determination
Sponsor: Rep Lincoln
Requestor:
COMPONENT SERIAL NO. 0 2 3 6

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	258.2	349.8	394.1	394.1	438.3	438.3
TRAVEL	2.0	2.0	2.0	2.0	2.0	2.0
CONTRACTUAL	18.0	18.0	21.0	21.0	24.0	24.0
SUPPLIES	1.8	1.8	2.1	2.1	2.4	2.4
EQUIPMENT	21.0	-0-	3.5	-0-	3.5	-0-
LAND & STRUCTURES	-0-	-0-	-0-	-0-	-0-	-0-
GRANTS, CLAIMS	-0-	-0-	-0-	-0-	-0-	-0-
MISCELLANEOUS	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL OPERATING	301.0	371.6	422.7	419.2	470.2	466.7
CAPITAL						
REVENUE FUND SOURCE:						

FUNDING: (Thousands of Dollars)

GENERAL FUND	150.5	185.8	211.3	209.6	235.1	235.1
FEDERAL FUNDS	150.5	185.8	211.4	209.6	235.1	235.1
OTHER FUND SOURCE:						
TOTAL	301.0	371.6	422.7	419.2	470.2	470.2

POSITIONS:

FULL-TIME	8	8	.9	9	10	10
PART-TIME	-0-	-0-	-0-	-0-	-0-	-0-
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

Estimate of current year impact: None

ANALYSIS: (Attach a separate page if necessary.)

SEE ATTACHED PAGE

Prepared By: Jan L. Hansen, Director
Phone: 465-3347
Division: Public Assistance
Date: 2/4/92
Approved by Commissioner: Theodore A. Mala, MD, MPH
Agency: Department of Health and Social Services
Date: 4/Mar/92

Distribution (by preparer): Leg. Fin., Legislative Sponsor, Requestor, OMB/DBR, Gov. Legis. Ofc., & Impacted Agency(ies).

Rev 10/7/91

FN 301.0 Public Assistance

DIVISION OF PUBLIC ASSISTANCE (DPA)
ANALYSIS - HB 498

NEW MEDICAID ELIGIBLES

HB 498 would increase the current income standards for pregnant women and infants in the Health Baby Program from 133% to 185% of the Alaska Federal Poverty Level (FPL). There will be 3 groups of eligibles affected by this legislation: Pregnant Women; Children born to mothers receiving medicaid; and Children whose mothers were not receiving medicaid at the time of birth.

Estimated Number of New Eligibles

1. 1417 newly eligible pregnant women in FY93;
2. 935 additional infants
3. 187 children under age one
4. Medicaid program application volume is expected to increase by 10% or 111 additional applications per month.

The increase in program qualifying standard is expected to provide Medicaid coverage to an additional 1417 pregnant women and 1122 children for a total 2539 eligibles. Assuming an average of two persons per case, the total caseload increase is 1270 cases month. The program application volume is increased by 111 additional applications per month.

New eligibility technicians in the Division of Public Assistance are required to review applications, conduct interviews, verify eligibility and authorize medical coupons for the new population of pregnant women and infants.

FY93 Staffing Need: Medicaid Pregnant Women/Healthy Baby

New cases per month	1270	Staffing standard 250 cases per ET Positions Needed 5.1
Applications per month	111	Staffing standard 86 apps per ET Positions Needed 1.3

Total Eligibility Technicians and support positions needed for new workload:

	FTE
Eligibility Technicians	6.4
Supervisor at 1:7 ETs	.9
Clerical at 1:5 ET/SU	.7
TOTAL FTE Positions	8.0

Following the change in program income standards from 133% to 185% of the Poverty Guideline Level, caseloads will gradually increase to the maintenance caseload levels projected above. In FY93 the eight Eligibility Technician staff are added in increments as the new caseload increases.

In FY94 all eight positions are budgeted at full 12-month equivalent. In FY95 and FY97 one additional Eligibility Technician is added for projected increase in the Pregnant Women/Healthy Baby caseload.

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. House Bill 498

Revision Date: March 3, 1992
Dept. Affected: DHSS
Title: An Act Relating to Medicaid Coverage for pregnant women and infants; and reordering the priori
BRU: State Health Services
Component: Nursing
Sponsor: Lincoln, Ellis, Ulmer, B.Davis, Gruenberg, Koponen, Bruckman
Requestor: House Finance Committee
COMPONENT SERIAL NO. 288

Expenditures/Revenues (Thousands of Dollars)

OPERATING	FY93	FY94	FY95	FY96	FY97	FY98
PERSONAL SERVICES	392.0	588.0	617.4	648.3	680.7	714.7
TRAVEL	49.0	70.0	73.5	77.2	81.0	85.1
CONTRACTUAL	63.0	90.0	94.5	99.2	104.2	109.4
SUPPLIES	7.0	1.0	1.1	1.1	1.2	1.2
EQUIPMENT	14.0	12.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	525.0	761.0	786.5	825.8	867.1	910.4
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	0.0	0.0	0.0	0.0	0.0	0.0
FEDERAL FUNDS	0.0	0.0	0.0	0.0	0.0	0.0
OTHER	525.0	761.0	786.5	825.8	867.1	910.4
TOTAL	525.0	761.0	786.5	825.8	867.1	910.4

POSITIONS:

FULL-TIME	7.0	10.0	10.0	10.0	10.0	10.0
PART-TIME	0.0	0.0	0.0	0.0	0.0	0.0
TEMPORARY	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of current year impact: N/A

ANALYSIS: (Attach a separate page if necessary)

Projections are based on need for 7 FTE Public Health Nurse I/II's in the first year and 10 in the second and succeeding years, plus adequate travel, equipment, materials,. to support the positions.

Formula: FY 93 new eligible children = 982 * 5 EPSDT screens 1st. yr. @ 45 minutes ea. + 15 min. ea. for blood lead level screens= 60 minutes per screen + 60 add'l. min. per screen req'd. for referrals, followup transportation, etc. = 2 hours PHN time per screen

FY 93 = 2hrs. * 5screens = 10 * 982 children = 9820/1500 avail. phn hours for direct service = 6.5 fte's

FY 94 = 2 * 5 = 10 * 1541 = 15410/1500 = 10.27 fte's

Prepared by: Peter M. Nakamura, MD, MPH
Phone: (907) 465-3090
Division: Public Health
Date: 3/3/92

Approved by Commissioner: Theodore A. Mala, MD, MPH
Date: 4 March 92
Agency: Department of Health and Social Services

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
OMB
Impacted Agency(ies)

(Rev 12/91)

FN 525.0 Public Health (Nursing)

POSITION PAPER
HOUSE BILL NO. 498

"An Act relating to Medicaid coverage for pregnant women and infants; and reordering the priorities granted to optional services under the Medicaid Program; and providing for an effective date."

Analysis:
Section 1 of HB No. 498 would amend AS 47.07.020(b) to add an optional coverage group to Alaska's Medicaid program: Pregnant women and infants whose monthly countable income is between 133% and 185% of the Alaska federal poverty level.

Section 2 of HB No. 498 would amend AS 47.07.030(b) to add an optional service to Alaska's Medicaid program: substance abuse rehabilitative services for pregnant women.

Section 3 of HB No. 498 would amend 47.07.035 to place case management and nutritional services for pregnant women #4 in the list of optional services and optional eligible groups to be deleted in the event that the Medicaid appropriation is insufficient to fund some or all optional services. (Those two services were added to AS 47.07.030 in 1988, but they were not placed in the priority listing of AS 47.07.035 at that time.)

Section 3 would add substance abuse rehabilitative services for pregnant women as #1 in the priority list of AS 47.07.035, first to be deleted in the event of a funding shortfall. Section 3 places the optional group of eligible pregnant women proposed by this bill 22nd in the listing of options to be deleted.

Discussion
In 1988, the Legislature added coverage for pregnant women and infants, then an optional group in federal law, up to 100% of the Alaska federal poverty level. Federal law changes later mandated that this group be a part of regular Medicaid coverage, and in 1990, a second change in the law mandated coverage up 133% of the Alaska federal poverty level. Currently, a state may opt to cover this group at any level between 133% and 185%. 16 States have 185% coverage, and 6 exceed 133%.

Alaska's "Healthy Baby" program initiative has been an incredible success, and it is actively promoted and supported by all of the Department's field and administrative staff and by the medical community around the state. In FY91, we estimate there were 12,000 births in Alaska; 4,724 women were enrolled in Medicaid (39.4%). (27% of the state's children under 3 are enrolled in Medicaid.)

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. HB 498

Revision Date:

Department Affected: DH&SS

Title: Medicaid/Pregnant Women and Infants

BRU: Medical Assistance/Administration

Component: Medicaid Facilities/Non-Facilities/Claims Processing

Sponsor: Lincoln

Requestor:

COMPONENT SERIAL NO. 0 2 3 0

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	40.2	22.0	24.2	26.0	27.9	30.0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	7,030.0	7,831.6	8,594.2	9,433.0	10,349.9	11,356.6
MISCELLANEOUS						
TOTAL OPERATING	7,070.2	7,853.6	8,618.4	9,459.0	10,377.8	11,386.6
CAPITAL						
REVENUE FUND SOURCE:						

FUNDING (Thousands of Dollars)

GENERAL FUNDS	3,525.1	3,921.3	4,303.2	4,723.0	5,181.9	5,685.8
FEDERAL FUNDS	3,545.1	3,932.3	4,715.2	4,736.0	5,195.9	5,700.8
OTHER FUND SOURCE:						
TOTAL	7,070.2	7,853.6	8,618.4	9,459.0	10,377.8	11,386.6

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY:						

Estimate of current year impact: 0

ANALYSIS: (Attach a separate page if necessary.)
Analysis attached

Prepared by: Kimberly Busch, Director Phone: 465-3355

Division: Medical Assistance Date: 3-4-92

Approved by Commissioner: Theodore A. Mala, M.D., M.P.H.

Agency: Department of Health and Social Services Date: 4-Mar 92

Distribution (by Preparer: Leg. Fin., Legislative Sponsor, Requestor, OMB/CBR, Gov. Legis. Ofc., & Impacted Agency(ies)

Rev 10/7/91

FN 7,070.2 Medical Asst (Medicaid)

ANALYSIS - HB 498 DMA Fiscal Note

New Medicaid Eligibles and Claims Payments

HB 498 would increase the current income standards for pregnant women and infants in the Healthy Baby Program from 133% to 185% of the Alaska Federal Poverty Level (FPL). There will be 3 groups of eligibles affected by this legislation:

Pregnant Women;

Children born to mothers receiving medicaid; and

Children whose mothers were not receiving medicaid at the time of birth.

Analysis of numbers of new eligibles and the program cost:

FY 93

We anticipate that the 39% increase to the income standards for pregnant women will result in a 30% increase in the number of eligible women. This is based upon the caseload increase due to the 1990 standards increase from 100% to 133% of the FPL.

A 30% increase to the 4724 pregnant women eligible in FY 92 is 1417 newly eligible pregnant women in FY 93. The average cost per eligible pregnant women in FY 93 is expected to be $2,703 (FY 92 cost of $2,562 x 5.5% inflation). Therefore, the 1417 pregnant women will cost an additional $3,830,151 in FY 93 (1417 x $2,703).

Children born to mothers receiving Medicaid are automatically eligible until they are one year old irrespective of the mothers' eligibility. We estimate 66% of the 1417 newly eligible pregnant women will give birth during the year, resulting in an additional 935 children in FY 93.

By providing the mothers of these children with Medicaid during pregnancy, the women with high-risk pregnancies become eligible for case management services. To the extent that they participate in case management, the frequency of "bad births" may be reduced. The size of the fiscal note could be discounted accordingly in further years.

Children under the age of one born to mothers who are <u>not</u> receiving Medicaid at the time of birth, but whose families' income later falls to between 133% and 185% of the FPL during their first year of life will also become eligible. This number is difficult to predict because we believe that most families with income under the 185% FPL will access medicaid eligibility for the mother. However, there will be some children whose family's income decreased after the birth month or who move into the state after their birth who will qualify. Based on anecdotal information from front line eligibility technicians, we expect this to be 20% of number of

re: 133-185%

children who are automatically eligible due to their mothers receiving medicaid at the time of birth, or 187 (20% of 935).

The average cost of children under the age of one in FY 93 is anticipated to be $2,767. This is based upon the average FY 92 cost of 2,623 x 5.5% inflation. Therefore, the total cost for the 1,122 new children will be $3,236,970.

The "average cost" includes all children in the age group, including those with profound physical problems at birth, resulting in extraordinary prenatal, birth, neonatal, and post neonatal costs, which are presently uncompensated and factored into facility rates as "charity care and bad debt". Were we able to calculate the value of that uncompensated care, this fiscal note could be discounted accordingly.

Total FY 93 Program Costs:

	Total	GF	Federal
Pregnant Women (1,417)	$ 3,830,151	$ 1,915,075	$ 1,915,075
Children (1,122)	3,104,574	1,552,287	1,552,287
Total All (2,539)	$ 6,934,725	$ 3,467,362	$ 3,467,362

FY 94

We estimate a caseload growth of 4% from the 1,417 newly eligible pregnant women in FY 93, or 1,474 pregnant woman. We also expect a 4% increase to the 1,122 children under one year old, for a total of 1167 children in FY 93.

The cost per eligible is expected in increase 5.5% due to inflation, thus the cost will be $2852 per pregnant women and $2,929 per child.

Total FY 94 Program Costs:

	Total	State GF	Federal
Pregnant Women (1,474)	$ 4,203,848	$ 2,101,924	$ 2,101,924
Children (1167)	3,418,143	1,709,071	1,709,071
Total (2641)	$ 7,621,991	$ 3,810,995	$ 3,810,995

FY 95 and forward:

Estimate the same percentage increases as for FY 94 (we did not adjust for possible discounted costs from improved pregnancy outcomes as explained in the above narrative).

Claims Processing Costs for new eligibles:

FY 93

We expect 75% of the total payments would be hospital claims at an average of $4500 per claims ($6,934,724 x 75% = $5,201,043 divided by $4,500 = 1156). The remaining 25% would be outpatient claims at an average of $141 per claim ($6,934,724 x 25% = $173,368 divided by $141 = 1230). This is 2386 claims processed at $6.23 per claim for a total processing cost of $14,865 (costs for claims processing are 75% federal and 25% state general fund match).

FY 94

Total payments of $7,621,991 using the same formula as above result in claims processing total costs of $15,830.

FY 95 and forward:

Same formula as above.

Substance Abuse Rehabilitation Services for Pregnant Women

We assume it is the intent of HB 498 to provide rehabilitative services to approved grantees of the Division of Alcoholism and Drug Abuse, and not to open those services to the private sector at this time. Initially, this services will cover treatment services (not room and board costs) for Medicaid-eligible pregnant women in all of the 4 grantee residential programs that accept or specialize in pregnant women services.

Fy 93 costs include one-time system contractual costs for establishing a new service in the Medicaid Management Information System, report modifications, and providers manuals and training for a total of $22.5 (75% federal, 25% state general fund match).

Because of the need to modify the system, promulgate regulations, and train providers, a start date of 1/1/93 is assumed for this service. FY 93 costs are estimated to pay for rehabilitative services during 2190 resident days, at a total cost of $95.3 (50% federal, 50% state general fund match).

FY 94 costs are computed at FY 93 x 2 (for a full 12 months) plus a 10% growth in service as capacity grows in residential treatment facilities and other grantees offering some pregnant women outpatient therapy services enroll as providers. FY 95 and forward, we assume a 10% growth rate (both increased number of clients and rate increases).

Contractual costs for claims processing, at $6.23 per claims, are estimated at $2.8 for FY 93, $6.2 for FY 94, and increasing at 10% per year thereafter. Costs are 75% federal, 50% state general fund.

Summary: Rehabilitation Services Only

	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
Contractual	$ 25.3	$ 6.2	$ 6.8	$ 7.5	$ 8.3	$ 9.1
Grants/ Claims	95.3	209.6	230.1	253.1	278.4	306.2
Total	120.6	215.8	236.9	260.6	286.7	315.3
GF	53.9	106.3	120.2	132.2	145.4	159.9
Federal	$ 66.7	$109.5	118.7	128.4	141.3	155.4

re: Substance abuse rehab

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

BILL NO. HB 498

Revision Date: _____ Department Affected: Health and Social Services

Title: An act relating to Medicaid Coverage

BRU: Alcohol and Drug Abuse Services

Component: Alcohol and Drug Abuse Grants

Sponsor: Representative Lincoln

Requestor: _____

COMPONENT SERIAL NO. 1 2 3 9

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	45.4	47.1	48.9	50.7	52.6	54.6
TRAVEL	10.0	10.5	11.0	11.6	12.2	12.8
CONTRACTUAL	5.0	5.3	5.6	5.9	6.2	6.5
SUPPLIES	1.0	1.1	1.2	1.3	1.4	1.5
EQUIPMENT	7.0	Ø	Ø	Ø	Ø	Ø
LAND & STRUCTURES						
GRANTS, CLAIMS	(19.1)	(41.92)	(46.02)	(50.62)	(55.68)	(61.24)
MISCELLANEOUS						
TOTAL OPERATING	43.3	22.08	20.68	18.88	14.72	14.16
CAPITAL	Ø	Ø	Ø	Ø	Ø	Ø
REVENUE FUND SOURCE:						

FUNDING: (Thousands of Dollars)

GENERAL FUND	45.3	22.08	20.68	18.88	14.72	14.16
FEDERAL FUNDS						
OTHER FUND SOURCE:						
TOTAL	45.3	22.08	20.68	18.88	14.72	14.16

POSITIONS:

FULL-TIME	1	1	1	1	1	1
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year impact: _____

ANALYSIS: (Attach a separate page if necessary.)

See Attached

Prepared By: Suzanne W. Perry Phone: 465-2071

Division: Alcoholism and Drug Abuse Date: 13-3-92

Approved by Commissioner: Theodore A. Mala, MD, MPH

Agency: Department of Health and Social Services Date: 4 Mar 92

Distribution (by preparer): Leg. Fin., Legislative Sponsor, Requestor, OMB/DBR, Gov. Legis. Ofc., & Impacted Agency(ies).

Rev 10/7/91 FN 43.3 Alcohol & Drug Abuse Page of

HB 498
Fiscal Note Analysis

There are two primary treatment facilities which regularly treat pregnant women. There is one treatment center which is exclusively for pregnant women, and there is one post-treatment (half-way house) facility for substance abusing women.

The costs of treatment in these facilities is as follows:

1. Juneau Recovery Unit (co-ed facility) $231/bed/day
   (specialized hospital), average length of stay 90 days

2. Reflections $96/bed/day
   This is a 12 bed women's only facility. Pregnant women get priority. Average length of stay 90 days

3. Dena A Coy $125/bed/day
   This is a pregnant women's only 18 bed facility. Average length of stay 200 days

4. New Dawn (Alaska Women's Resource Center) $70/bed/day
   This is a 10 bed women's only halfway house or post-treatment facility. Pregnant women get priority if they refuse Dena A Coy or are not accepted for some reason. Average length of stay 120 days.

The average cost is $130/bed/day if all facilities are included. If only the primary treatment facilities are included, the average cost is $150/bed/day.

As medicaid will not pay for room and board costs, we estimate treatment costs to be 70% of the total cost. Therefore, of a total cost of $150/bed/day, $105 would be medicaid reimbursable.

The assumptions which were used to develop the fiscal impact on grants include the following:

FY 93 -- six months of regulation development, and program training followed by six months of actual client activity.

Assuming JRU saw 3 pregnant women during the year with each remaining in treatment for 90 days, their cost would be $43.7.

Assuming Reflections saw 6 pregnant women during the year with each remaining in treatment for 90 days, their cost would be $24.2.

Assuming Dena A Coy saw 6 pregnant women during the year with each remaining in treatment for 200 days, their cost would be $105.0.

Assuming New Dawn (AWRC) saw 6 pregnant women during the year with each remaining in treatment for 120 days, their cost would be $17.6.

It is estimated that each year would see a 10% increase over the initial year.

The Division of Alcoholism and Drug Abuse recently began collecting information on pregnancy status of women. It is not possible to determine from available information how many of these women were medicaid eligible.

Substance abuse treatment for pregnant women is a relatively new approach, and targeting medicaid eligible women has not historically been done.

During the transition period, one full year after the regulations are effective, it is anticipated that treatment centers would be required to hire and train additional staff to handle medicaid billings. While this staff would not necessarily be full time, it is anticipated that a part-time person would be necessary. Therefore, a retention of 80% of grant funds would be required during this transition period. That is, for each $100 of medicaid to be reimbursed, $80 of grant funds would not be supplanted, but would be retained. After the programs have trained staff hired, this retention would no longer be necessary.

It is also anticipated that the Division of Alcoholism and Drug Abuse would require a staff specialist in medicaid to assist programs with this effort. This position would be located in Anchorage as three out of four of the programs currently seeing pregnant women are located in Anchorage. This position would be an Administrative Assistant II at a range 14. This position would be able to provide written and on-site technical assistance to all programs seeing pregnant women. The current COLA of 3.6% was used for salaries and 5% used for other costs after FY '93. It is anticipated that this position could be Medicaid funded. However, further analysis must occur prior to determining this possibility.

HOUSE COMMITTEE REPORT

(7)

Date Referred: February 18, 1992 FURTHER REFERRALS: Finance

Date of Committee Action: 3/17

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 498

HOUSE BILL NO. 498 MEDICAID FOR PREGNANT WOMEN/INFANTS

"An Act relating to Medicaid coverage for pregnant women and infants; and reordering the priorities granted to optional services under the Medicaid program; and providing for an effective date."

RECOMMENDATIONS: [ ] the same title
be replaced with CS HB 498 (HES) [ ] a new title

[ ] have attached amendments(s)

[✓] do pass

[ ] do not pass

[ ] no recommendations

[ ] individual recommendations

[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[✓] fiscal impact DHSS

[ ] zero fiscal note _____

APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____

SIGNING DO PASS	*DP*	*OTHER RECOMMENDATIONS*	*DNP*	*NR*	*AM*
	✓				
	✓				
Bettye Davis	✓	Mary Miller		✓	
Chris Davis	✓	J. G. Gonzales		✓	

CHAIRMAN'S SIGNATURE

FACT SHEET - provided by Sharon Landman-Zeman. FAS Coordinator State of Alaska

- In 1981, the Surgeon General of the United States issued a health advisory recommending that women who are pregnant or are considering pregnancy should abstain from alcoholic beverages and should be aware of the alcohol content of foods, beverages and medications. In addition, he urged doctors to monitor the drinking habits of pregnant patients and those considering pregnancy, and encourage pregnant patients not to drink. (Office of the Surgeon General, 1981)

- Fetal Alcohol Syndrome (FAS), officially identified in the U.S. in 1973, is a pattern of mental and physical defects that develop in infants born to some women who drink heavily during pregnancy. ("Fetal Alcohol Syndrome", Alcohol Topics in Brief, NIAAA, April 1985, p. 1)

- Fetal Alcohol Syndrome (FAS) is now recognized as the leading known cause of mental retardation in the Western world and the only one that is totally preventable. (E. Abel and R. Sokol, "Incidence of Fetal Alcohol Syndrome & Economic Impact of FAS-Related Anomalies", Drug & Alcohol Dependence, 19, 1987, pp. 51-70)

- The world-wide incidence of FAS is 1.9 per 1,000 live births. In the United States, estimates of the number of yearly FAS births world be 3,600 to 10,000. (E. Abel and R. Sokol, "Incidence of Fetal Alcohol Syndrome and Economic Impact of FAS-Related Anomalies, Drug & Alcohol Dependence, 19, 1987, pp. 51-52)

- The incidence of Fetal Alcohol Effects (FAE) is estimated to be three to four times greater than FAS or up to 40,000 infants each year (Seventh Special Report to the U.S. Congress on Alcohol and Health, January, 1990).

- Whenever drinking is stopped during pregnancy, the risks of fetal alcohol effects and consequences of alcohol exposure are decreased. (J. Funkhouser and R. Denniston, "Preventing Alcohol-Related Birth Defects", Alcohol Health & Research World, NIAAA, Vol. 10, No. 1, Fall 1985, p. 56)

- Eight million American women out of 56 million of childbearing age (15-44 years) currently use one or all of four drugs: Alcohol, cocaine, marijuana, and nicotine. These drugs all appear on the official list of human teratogens, i.e. substances that cause birth defects. (E. Adams, NIDA, The New York Academy of Sciences, Fall 1988, Vol. 3, No. 2, pp. 1, 10-11)

- New York spends an estimated $43,680 per victim of FAS per year, for a lifetime cost of $2,620,000 per child. (Center for Science in the Public Interest, 1986)

SPECIAL CURRENTS™
Maternal Addiction

C. Everett Koop, MD, ScD, *the Surgeon General of the United States from 1981 to 1989, is currently writing, lecturing, and producing five 1-hour documentaries on health-related issues for NBC-TV. Dr. Koop's introduction for* Special Currents: Maternal Addiction *appears below.*

Introduction

Looking rationally and compassionately at women who are addicted, we find—as Dr Loretta Finnegan points out elsewhere in this newsletter—that substance-abusing women are many times more likely than other women to have suffered sexual abuse when they were children, and much more likely than others to have had a drug- or alcohol-dependent parent. Drug- and alcohol-exposed infants are thus very likely to represent a second—or a third—generation of abused children.

Assigning blame to the dysfunctional family or any of its members will not stop or prevent abuse. Incarcerating pregnant abusers will not stop fetal drug exposure. Addicted women, who typically have remarkably low self-esteem, need help to build the self-respect and confidence required to conquer a chronic, relapsing disease.

We are best advised to help these victimized women gather strength and real power to supplant the fleeting sense of strength and well-being they find in drug use. The optimal time for them to recognize their real power is during pregnancy, when many women feel self-worth for the first time—a fact that also accounts, in part, for our astonishing rates of teenage pregnancy.

Comprehensive, family-oriented treatment is essential. Punitiveness, cynicism, hopelessness, and stereotyping are contraindicated. Professionals in medicine, nursing, social service, and law enforcement must learn more about prevention and treatment of substance abuse. In 12-step and residential programs, where recovering addicts have the encouragement, opportunity, and means to help others break free of the abuse cycle, one success can be multiplied many times. In the health care professions, we feel substantial gratification upon effecting a successful cure for a difficult illness: If such gratification is available to recovering substance abusers, their redirected energy can grow exponentially and control or eliminate this epidemic.

Maternal Addiction *is the second* Special Currents *Ross Laboratories has published to help health care professionals combat the drug epidemic. The first focused on cocaine-exposed infants; the aim of this second issue is to help prevent such exposure by elucidating the broader topic of maternal addiction.*

Loretta P. Finnegan, MD, *Professor of Pediatrics and Professor of Psychiatry and Human Behavior at Jefferson Medical College of Thomas Jefferson University in Philadelphia, has taught and lectured throughout the world. Her contributions to perinatology and neonatology have resulted in hundreds of publications and presentations, although she is perhaps best known for devising the standard assessment scale for neonatal withdrawal.*

Dr Finnegan is also founder and Director of Family Center, a model comprehensive treatment center for pregnant addicted women and their children, located at Jefferson Hospital in Philadelphia. Since February 1990, she has also served as Associate Director of the Office for Treatment Improvement and Associate Director for Medical and Clinical Affairs of the Office for Substance Abuse Prevention in the Alcohol, Drug Abuse, and Mental Health Administration of the US Department of Health and Human Services.

Maternal Addiction

Addiction is a chronic, relapsing disease that affects all sectors of our population. It is now widely recognized that millions of Americans use illicit drugs regularly. Many millions more are addicted to nicotine, alcohol, or both. Large numbers of people die every day as a result of nicotine's role in heart disease, lung disease, and cancer. The effects of alcoholism have wreaked incalculable damage across generations in our society. The epidemic of drug abuse has overwhelmed American women and children.

The many negative effects of drug exposure on newborns are familiar to neonatologists and are now recognized by pediatricians.[1-9] A 1989 survey conducted by the House Select Committee on Children, Youth, and Families[10] found 15 of 18 hospitals reporting three to four times as many drug-exposed births in 1989 as in 1985; since the 3 hospitals not reporting an increase kept no records of fetal and maternal drug exposure, and none of the 18 hospitals screened routinely for drug exposure, the reality is probably even worse.

The AIDS epidemic complicates this picture. Newborns who test positive for human immunodeficiency virus (HIV) usually have parents who were drug abusers or whose partners were drug abusers.[11] Many of these infants are "boarder babies" living in large city hospitals, physically impaired and abandoned by their parents. These

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back-up re maternal addiction

babies will be placed in foster care—when it is available—outside their families immediately on leaving the hospital.

In May 1989, the Children's Defense Fund[12] reported on the daily lives of our children: In America, *every day*, 1,293 teenagers give birth, 1,849 children are abused, 68 babies age <1 month die, and 107 babies age <1 year die.

Child abuse and drug abuse go hand in hand. In New York City, 59% of the child abuse and neglect fatalities involving children previously known to the authorities occur within the first 6 months of life—and these are usually drug-exposed babies.[13] In the District of Columbia, almost 90% of those reported for child abuse or neglect are active substance abusers.[13]

In Boston, prenatal care is free for all low-income mothers. Nonetheless, between August 1988 and February 1989, 38 babies were born at Boston City Hospital to mothers who had no prenatal care, and 37 of the babies tested positive for cocaine.[13]

The tragic impact of alcohol on infants and children is well known. The incidence of fetal alcohol syndrome is estimated to be one to three cases per 1,000 live births, or about 4,000 to 12,000 new cases in the United States each year. This preventable disease is one of the leading known causes of mental retardation.[14]

Within the context of comprehensive services for pregnant drug-dependent women at Thomas Jefferson University Hospital over the last 20 years, we learned a great deal through clinical observations and various research studies. We have found that addiction is more than a medical issue. It encompasses physical, psychologic, and sociologic issues. The majority of women who are drug-dependent do not seek prenatal care and therefore have an increased incidence of obstetrical and medical complications. The common medical complications seen in these women include anemia, poor nutrition, and various infectious problems, including pneumonia, tuberculosis, urinary tract infections, sexually transmitted diseases, and now, HIV disease. Many of these women also present with the complications associated with needle use, including hepatitis, thrombophlebitis, cellulitis, abscesses, and ulcers.

Obstetrical complications abound. These include amnionitis, chorioamnionitis, premature rupture of membranes, abruptio placentae, intrauterine growth retardation, and preterm birth. The host of medical and obstetrical complications experienced by these women demand that a large number of their infants be admitted to neonatal intensive care units for observation and treatment.

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SPECIAL CURRENTS: MATERNAL ADDICTION

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Moreover, the women are further weakened by unemployment, illiteracy, homelessness, and legal issues. Many environmental variables have contributed to addictive behaviors. At least 70% of drug-dependent women have experienced sexual abuse before reaching age 16 years, and 83% have a parent who was addicted to alcohol or illicit drugs.[4]

Drug addiction is one of the most debilitating diseases due to its chronicity and intermittent relapses. Moreover, and specifically with regard to children, it has long-range and intergenerational implications. Addiction is even more devastating to drug-dependent pregnant women and mothers, who frequently do not have the resources for recovery available to them. The words of one of our patients, a 35-year-old white woman with three children who was physically and sexually abused as a child by her alcoholic father and who began to use psychoactive drugs after her mother died when she was 15, are most relevant. She says, "Drug addicts are human beings who have the same hopes and dreams that you do. Drug-addicted mothers love their children just like any other mother. I love my children, but it is not easy to stop using drugs. Treatment has helped me to recognize how my background has influenced my addiction. I medicated my pain for a very long time. Now I can talk about this pain and face it without running away through the euphoria of drugs."

Among industrialized countries, the United States ranks 22nd in infant mortality. In the state of Pennsylvania, nearly 1,700 babies die within their 1st year of life—a rate that far exceeds the US national rate of 10 deaths per 1,000. The primary cause of infant mortality is low birth weight, and it is often the result of lack of quality prenatal care. By treating potential problems early in pregnancy, much can be done to prevent premature birth and associated complications—a fact that we have known for many decades.

Although the overwhelming majority of women needing prenatal care are poor, lack of care during pregnancy is not confined to the disadvantaged. Many middle-income families also fall into the cracks, due to the lack of adequate health insurance. Approximately one fifth of pregnant women do not receive sufficie. ' prenatal care.

The results are tragic. Without prenatal care, women are three times as likely to give birth to a low-birth-weight baby—one that will be 40 times as likely to die during his or her first 4 weeks of life than a normal-birth-weight infant. Many of those who live will require custodial care, sometimes for the rest of their lives. The cost to "graduate" a sick infant from the intensive care unit can be $150,000 for the first 3 months ·· life. In spite of this tremendous cost, some never surv' :o 1 year of age. Lifetime custodial care for these prema y born babies can cost upwards of $400,000. Yet, if w /ould just spend a few hundred dollars for each pregnant woman for prenatal care, a substantial percentage of these costs could be avoided.

Drug- and alcohol-addicted women contribute the most to perinatal morbidity and mortality. Drug-dependent women are characterized by no or very little prenatal care, with a resultant incidence of 40% to 50% preterm birth, and no or inadequate drug abuse treatment.[2] Currently in Pennsylvania, these women represent 5% to 35% of deliveries in various hospitals across the state. A recent study in Philadelphia has shown that a mean of 16.7% of women delivering in eight center-city hospitals had

positive urine toxicologies or positive histories for cocaine. Some hospitals had percentages greater than 20%.[15] In 1989, research at our hospital revealed that 15% of 852 women tested had positive toxicology studies for cocaine or combinations of cocaine, marijuana, and narcotics. This percentage was equally distributed among our private and medical-assistance patients. Clearly, this is not an issue for poor minorities alone: Infants in all socioeconomic and ethnic groups are adversely affected.

Research has shown that we *can* rehabilitate a significant number of women who have enrolled in comprehensive treatment services during pregnancy.[4] We can reduce maternal and infant morbidity and mortality. When maternal medical and obstetrical complications are treated, a similar outcome has been seen in the drug-dependent mothers as in the drug-free mothers of the same socioeconomic and ethnic class. Moreover, one can reduce the incidence of low-birth-weight infants from nearly 50% to less than 20%—a significant reduction in terms of neonatal morbidity, mortality, and medical cost.

"We must recognize addiction as a chronic, relapsing disease."

We must recognize addiction as a chronic, relapsing disease. Because each addicted woman is different from all others, treatment plans should be individualized. Comprehensive services must include high-risk prenatal care, and clinics must be staffed by obstetricians specifically trained in the field of addiction and high-risk pregnancy. Additional treatment modalities should include individual, group, and family therapy. Methadone maintenance and inpatient detoxification should be available, since methadone has proven effective for opiate addiction. Various studies have shown the lack of morbidity and mortality in opiate-addicted women who are provided with methadone maintenance—in contrast to those women who continue the use of street heroin. When the women combine opiate use with alcohol, barbiturates, or tranquilizers, it is frequently necessary to detoxify them in an inpatient setting to avoid any untoward effects upon the pregnancy.

AIDS prevention, counseling and testing, and educational services in the form of prenatal and parenting classes must be available. Services should be aimed at eliminating drug use, developing personal resources, improving family and interpersonal relationships, reducing and eliminating socially destructive behavior, and facilitating maximum obtainable adaptation for new parents within their environment.

Infants who exhibit withdrawal symptoms should be in newborn nurseries where neonatal physicians are experienced in the field of neonatal drug exposure. Routine protocols for the low-birth-weight infant, for neonatal infection, and for those undergoing abstinence are commonly used in evaluation and treatment. Long-term follow-up studies in our clinic have demonstrated that by providing these perinatal services to this very high-risk population, we give these infants and children the chance to be developmentally, neurologically, and physically normal.

The families of drug-addicted women have higher levels of family conflict and physical violence and lower levels of family cohesion. Treatment, therefore, must respond to every one of the medical and social variables that complicate addiction and recovery. For instance, while methadone may encourage a heroin-free existence, reduce exposure to HIV, and permit us to have healthier infants, it does not answer the social problems faced by the women enrolled in programs such as Jefferson Family Center. These women have problems associated with support issues, food access, housing, and day care—the issues that are most overwhelming to the recovering female addict. Relapse is imminent when daily survival is at risk.

"Relapse is imminent when daily survival is at risk."

In the United States, due to the lack of treatment services and research endeavors within the drug-addicted population for so many years, we are now plagued with rampant drug addiction. Because of the intergenerational transmission of the disease of addiction, we have fostered a spiraling legacy of addicts giving birth to addicts. This dark reality of gloom has now developed so far that we will soon have many thousands of babies dying of AIDS. We also have the concomitant tragedy of babies who are disabled not only by premature birth and congenital malformations, but also by a debilitating psychosocial environment.

We have had a drug abuse epidemic for a quarter of a century, and due to the lack of resources for treatment, research, and education, as well as the lack of interest by professionals, we haven't done anything effective to reduce this devastation upon women and children. We have now reached uncontrollable heights in this epidemic. This generation of children is suffering due to our previous unwillingness to act with urgency to turn the tide against this tragedy that has befallen them.

We must remove the barriers to effective prevention, intervention, and treatment of drug-dependent mothers and children. We must provide appropriate treatment by caring professionals who are knowledgeable in the field of substance abuse, and we must put the treatment of women into the context of their reality. For example, the woman who is cocaine-dependent without any resources or support systems and who has three children cannot be asked to come every day to a treatment program. To be able to know what she must do for her children, to be able to provide for those children economically, emotionally, and spiritually, she must be in a residential treatment setting.

Aside from the intensive drug rehabilitation and medical treatment, these women need extensive educational and job training so that they will become productive citizens and loving and giving mothers who will positively influence the development and socialization of their children. Residential treatment can serve to eliminate the medical and social problems experienced by the drug-dependent woman and her children, particularly those who are cocaine dependent and for whom there is no pharmacotherapeutic agent such as methadone.

Incarceration is not the appropriate choice for drug-dependent women who have not had the financial, emotional, educational, and spiritual advantages that most of us have had. Instead, treatment on need must be available for the mother with her children, not only for the rehabilitation of these women and children, but also for the

sake of future children. Appropriate services for the follow-up of pregnant drug-dependent women are essential. The issues of child abandonment and increased needs for foster care must also be addressed and planned for appropriately.

Still more devastating illicit drugs are appearing in our cities.[16] The above treatment and service recommendations are the least that we must do to assure that future children born in our country will not be tormented by drug addiction and the likelihood of being physically and psychologically disabled throughout their lives. If we follow these recommendations, we may have hope for these children and avoid the destruction of the very fiber of our country—the family.

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Carol Tracy, JD, *is Executive Director of the Mayor's Commission on Women for the city of Philadelphia. Ms Tracy has been instrumental in developing treatment centers for women in Philadelphia, and has lectured and published widely on women's issues. At the Ohio Perinatal Association in March 1990, she presented an analysis of current drug policies and their effects.*

Women, Abuse, Addiction, and Public Policy

The most profound impact of the drug epidemic has been on women and their children. An estimated 5 million women of childbearing age use illegal substances, and 1 million use cocaine[1]—as many as 10% of pregnant women use cocaine.[2] In Philadelphia[3] and Boston,[4] 17% of women use crack cocaine during pregnancy.

Crack use leads to feelings of power, confidence, and energy; it is one of the most addictive drugs known.[5] Its dramatic effects, seen in emergency rooms, maternity services, neonatal intensive care, and pediatric units are causing long-overdue public alarm.[6] Despite this unprecedented crisis, very few treatment resources are available for mothers with children and pregnant women; indeed, pregnant women—the source of most public concern—are the group least likely to find access to treatment.

Most treatment programs do not treat medical complications of pregnancy, so they do not accept pregnant women.[7] Approximately 70% of those in treatment are men, 80% of treatment resources are spent treating men,[8] and most of the treatment available for women is based on male-oriented models.[9] Most use a confrontational, punitive treatment modality that is insensitive to the multiple and complex needs of addicted women. Very few programs make any accommodations for children.

Although most treatment research has focused on men, ample information is available about the problems of women, what women need, and what they will respond to in treatment. For example, there is a strong correlation between the experiences of incest and other forms of child sexual abuse and chemical dependence in women.[9-13] The literature also suggests that women who have been sexually abused as children have difficulty establishing open, trusting relationships as adults; they tend to become depressed and have difficulty with sexual expression. They often continue to be physically and sexually abused as adults, a fact that has obvious implications for their parenting abilities.[12] Many are themselves the children of substance abusers.

Because men do not often stay with addicted women unless they are themselves addicted,[14] these women usually have no male support: They are as isolated and marginal in the drug culture as in the rest of society.

Pregnant women should be given absolute priority for treatment, and treatment programs for women should be expanded and redesigned. The traditional confrontational style of treatment does not work for addicted women: Many of these women can't respond to humiliation because they have already lost self-esteem, or never had a chance to develop the feelings of competence that lead to self-esteem. Because a significant body of social science research shows that women shut down in mixed-sex

groups, where their issues are neither heard nor addressed,[15] treatment services should be run by women.

Women-centered programs need appropriate accommodations for children, and should include family planning and other health care. Substance abuse counselors should be trained to deal with issues related to sexual and domestic violence. After-care support services and links to adequate housing, education, training, and employment services should also be provided.

Although the need for services still greatly exceeds the capacity, some of the major elements for responsible and appropriate treatment and support are beginning to develop in Philadelphia. We have a 24-hour hotline that provides referral, counseling, and support (Women in Transition); a women-only detoxification unit (Diagnostic and Rehabilitation Center [DRC] Women's Program); two 28-day women's residential rehabilitation programs (DRC and Girard Medical); a 6-month residential program for single women (Interim House); and four 6-month-plus residential programs for pregnant women and mothers and their children (Gaudenzia's New Image and Kindred House; Genesis II's Caton House; DRC's Hutchinson House). Two more residential programs will open this year (Episcopal Hospital and Family Center), and one of these will work exclusively with pregnant women (Family Center).

In addition, we have an intensive outpatient program that provides child care and other support services, including case management (Women's World), and a specialized outpatient program for pregnant and postpartum women providing intensive medical, psychosocial, and social service supports (Family Center). Four prenatal programs have substance abuse counselors, and family planning counselors provide services to women in treatment throughout the system.

Some transitional housing programs are in place for recovering mothers with children, including a program for recovering substance-abusing women who have been victims of domestic violence. Substance abuse counselors have been trained by domestic violence workers, and domestic violence programs have substance abuse counselors on staff.

Finally, an innovative program is being set up by the Philadelphia Department of Human Services and the Coordinating Office of Drug and Alcohol Abuse of the Department of Public Health to provide substance abuse counseling and other support services to families that have been identified as having children at risk for abuse and neglect due to parental drug abuse. It is called the Family Preservation Program.

Some of the most effective substance abuse treatment for women is in long-term residential facilities where they can live with their children. Currently, there are 21 such programs in the United States (a doubling in the last 2 years).[7] In these programs, women not only participate in counseling related to their substance abuse, but they receive or have access to education, vocational counseling, and training; they learn how to develop or improve their parenting skills; and they participate in the overall functioning of the program, eg, cooking, cleaning, shopping, financial planning, etc.

general disorganization.[16] Insofar as we live in a society that still conditions little girls and women to believe that a Prince Charming will come along to take care of them, we train women to believe that they do not need to make decisions, that they are not good at making decisions—indeed, that they are not entitled to make decisions. We condition girls and women to defer to someone else's authority. Women who have been socialized to be dependent and passive and to believe that they are not entitled to make decisions about their lives and bodies have not been able to develop the skills to combat the crises we are now facing.[15] Calls for equality and genuine self-determination for women are not empty rhetoric, but the means for survival.

Many people hate addicted mothers for what they are doing to their children, and such hostility is understandable. An addict under the influence of crack exhibits few virtues, and many mothers are behaving hatefully. We will not save children, however, if we do not work with their mothers.

Blaming the victim is not productive. Some states have enacted laws that declare mothers whose infants test positive for drugs at birth to be child abusers, and prosecutors seem eager to jail women who use drugs during pregnancy.[7,17] Our public policy towards women sometimes reflects a desire to punish that outweighs the desire to help and heal. For example, until about 15 years ago, the typical public response to a woman who was being battered was to have her children removed from the home and, in many parts of the country, this practice is still followed. Until grassroots women's organizations set up shelters and safe houses for women and their children, women who asked for help and protection from abusive husbands would often lose their children.[18]

Laws declaring that pregnant substance-abusing women are child abusers will more likely send addicted women deeper underground, away from prenatal care and other health and treatment services, than keep them away from drugs. Drugs are available in many jails and prisons. Programs are needed to create alternatives and protect the children while treating, not punishing, their mothers.

Historically, plagues have been met with hatred of those who are afflicted, and denial that the disease is close at hand for those yet unafflicted.[19] Hatred and denial have slowed the pace of medical and political interventions to combat AIDS, for example. The crack epidemic, coincident with intractable poverty, carries a new threat that can lead to social havoc: It destroys the most powerful, fundamental, primary social relationship—that of mother and child.[20]

In some ways, the drug crisis has brought the issues that oppress women more clearly in focus. Domestic violence; rape; child sexual abuse; incest; poor or no prenatal care; infant mortality; lack of economic security, self-esteem, and structural supports for mothers; and racism directed at women in minority groups are all part of the same cycle. To combat the drug crisis successfully, we must acknowledge and address all these issues. Today's crack mothers were yesterday's abused children, and without immediate and massive intervention, today's drug-exposed newborns could be tomorrow's psychopaths.

TABLE 1

OBRA - 86/87/89 SUMMARY STATUS
MEDICAID COVERAGE OPTIONS FOR PREGNANT WOMEN AND CHILDREN

	PREGNANT WOMEN AND INFANTS % OF POVERTY *	CHILDREN AGE 6 TO 8 % OF POVERTY	EFFECTIVE DATE OF ORIGINAL EXPANSION
Alabama			Jul-88
Alaska			Jan-89
Arizona	140%	100%	Jan-88
Arkansas		100%	Apr-87
California	185%	100%	Jul-89
Colorado			Jul-89
Connecticut	185%		Apr-88
Delaware		100%	Jan-88
DC	185%	100%	Apr-87
Florida	150%	100%	Oct-87
Georgia			Jan-89
Hawaii	185%	100%	Jan-89
Idaho			Jan-89
Illinois			Jul-88
Indiana			Jul-88
Iowa	185%	100%	Jan-89
Kansas	150%		Jul-88
Kentucky	185%		Oct-87
Louisiana		100%	Jan-89
Maine	185%	100%	Oct-88
Maryland	185%		Jul-87
Massachusetts	185%		Jul-87
Michigan	185%		Jan-88
Minnesota	185%	100%	Jul-88
Mississippi	185%		Oct-87
Missouri			Jan-88
Montana		100%	Jul-89
Nebraska			Jul-88
Nevada			Jul-89
New Hampshire			Jul-89
New Jersey			Jul-87
New Mexico			Jan-88
New York	185%		Jan-90
North Carolina	185%	100%	Oct-87
North Dakota			Jul-89
Ohio			Jan-89
Oklahoma			Jan-88
Oregon			Nov-87
Pennsylvania			Apr-88
Rhode Island	185%		Apr-87
South Carolina	185%		Oct-87
South Dakota			Jul-88
Tennessee	150%		Jul-87
Texas			Sep-88
Utah			Jan-89
Vermont	185%	100%	Oct-87
Virginia			Jul-88
Washington	185%	100%	Jul-87
West Virginia	150%	100%	Jul-87
Wisconsin	155%		Apr-88
Wyoming			Oct-88
TOTAL	24	16	

* EFFECTIVE APRIL 1, 1990 STATES MUST COVER PREGNANT WOMEN AND CHILDREN TO AGE 6 AT 133% OF THE FEDERAL POVERTY LEVEL. FOR THOSE STATES THAT HAVE EXPANDED COVERAGE BEYOND THE MANDATED 133%, THIS COLUMN INDICATES THE PERCENTAGE OF POVERTY ADOPTED BY THE STATE.

states with expanded coverage

State of Alaska
Division of Public Assistance

STANDARDS AND MAXIMUM PAYMENTS

Revised 1/1/92

AFDC		3.5% 1/1/84	3.5% 1/1/85	3.1% 1/1/86	7/1/86	1.3% 1/1/87	4.2% 1/1/88	4.0% 1/1/89	4.7% 1/1/90	5.4% 1/1/91	3.7% 1/1/92
AI	2	617	638	657	657	665	692	719	752	792	821
	3	696	719	740	740	749	779	809	846	891	923
	4	775	800	823	823	833	866	899	940	990	1025
	5	854	881	906	906	917	953	989	1034	1089	1127
	6	933	962	989	989	1001	1040	1079	1128	1188	1229
	7	1012	1043	1072	1072	1085	1127	1169	1222	1287	1331
EACH ADDITIONAL		79	81	83	83	84	87	90	94	99	102
AFDC-IHCAP/ AFDC-UP	2	536	554	570	570	577	599	621	*648	682	705
	3	762	788	811	811	821	854	887	*927	976	1011
	4	841	869	894	894	905	941	977	*1021	1075	1113
* AFDC-UP	5	920	950	977	977	989	1028	1067	*1115	1174	1215
EFF. 10/1/90	6	999	1031	1060	1060	1073	1115	1157	*1209	1273	1317
	7	1078	1112	1143	1143	1157	1202	1247	*1303	1372	1419
EACH ADDITIONAL		79	81	83	83	84	87	90	*94	99	102
ANI	1	246	254	261	261	264	275	286	299	315	326
	2	492	508	522	522	528	550	572	598	630	653
	3	571	589	605	605	612	637	662	692	729	755
	4	650	670	688	688	696	724	752	786	828	857
	5	729	751	771	771	780	811	842	880	927	959
	6	808	832	854	854	864	898	932	974	1026	1061
	7	887	913	937	937	948	985	1022	1068	1125	1163
EACH ADDITIONAL		79	81	83	83	84	87	90	94	99	102
SINGLE ADULT/ PREGNANT WOMAN		391	404	416	416	421	437	453	473	498	515
APA					WASKY SUIT						
A INDIVIDUAL		566	586	605	624	632	659	685	717	756	784
B INDIVIDUAL		466	482	497	516	523	545	567	594	626	649
A COUPLE, ONE ELIG.		683	707	730	749	759	791	823	862	909	943
B COUPLE, ONE ELIG.		536	555	573	592	600	625	650	681	718	745
A COUPLE, BOTH ELIG.		830	859	887	925	937	976	1015	1063	1120	1161
B COUPLE, BOTH ELIG.		683	707	730	768	778	811	843	883	931	965
NH PERSONAL NEEDS		70	70	70	70	70	70	75	75	75	75
NH 300%		942	975	1008	1008	1020	1062	1104	1158	1221	1266
SSI STANDARDS											
A INDIVIDUAL		314	325	336	336	340	354	368	386	407	422
B INDIVIDUAL		209.34	216.67	224	224	226.67	236	245.34	257.34	271.34	281.34
A COUPLE		472	488	504	504	510	532	553	579	610	633
B COUPLE		314.67	325.34	336	336	340	354.67	368.67	386	406.67	422
NH PERSONAL NEEDS		25	25	25	25	25	25	30	30	30	30
APA/SSI RESOURCE LIMITS											
INDIVIDUAL		1500	1600	1700	1700	1800	1900	2000	2000	2000	2000
COUPLE		2250	2400	2550	2550	2700	2850	3000	3000	3000	3000

FEDERAL POVERTY LEVELS	FAMILY SIZE	100% OMB SIX-UP	133% PREGNANT WOMAN HEALTHY CHILDREN	185% TRANSITIONAL MEDICAID	200% QDWI
ALASKA MONTHLY STANDARDS	1	690	918	1278	1381
	2	925	1231	1712	1851
EFFECTIVE 4/1/91	3	1160	1543	2147	
	4	1395	1856	2582	
	5	1630	2169	3017	
	6	1865	2481	3451	
	7	2100	2794	3886	
	8	2335	3106	4321	
	EACH ADDITIONAL	235	312	434	

INTERNET 2/15/92